MEETING MINUTES

Project Name: IPRS	**Doc. Version No:** 1.0	**Status:** Final

Meeting Name:	IPRS Core Team Meeting
Facilitator:	Eric Johnson, DMH
Scribe:	Carlisa Stallings
Date:	01/31/2007
Time:	10:30 – 11:30 a.m.
Location:	Hargrove, Conference Room D

IPRS Core Team Attendees:

X	Rick Kretschmer		**Others:**
	Sarah Harris		Tim Sullivan
x	Cheryl McQueen	x	Jamie Herubin
	Sara Parks	X	Sandy Flores
	Gary Imes	x	Mike Frost
	Joyce Sims	X	Myran Harris
x	Rick Debell		Chris Ferell
X	Carlisa Stallings	X	Deborah LeBlanc
x	Thelma Hayter		Debra Haraway
x	Eric Johnson	X	Cathy Bennett

Attendees:

x	Alamance-Caswell	x	Onslow-Carteret
x	Albemarle	x	OPC
x	Catawba	x	Pathways
x	Centerpoint	x	Pitt
	Crossroads	x	Roanoke-Chowan
x	Cumberland	x	Rockingham
x	Durham	x	Sand hills Center
x	Eastpointe	x	SE Center
x	Edgecombe-Nash		SE Regional
x	Five – County MHA	X	Smoky Mountain
x	Foothills	x	Tideland
	Guilford	X	Wake
x	Johnston	x	Western Highlands
x	Mecklenburg	X	Wilson-Greene
x	Neuse		
x	New River		

Attendees:

Item No. Topics

1. Roll call

2. Please mute phones or refrain from excess activity to help with communications. Please state your name and which "area program" you are from when you speak. **Also, please do not place IPRS Core Team call on hold because of potential distraction to call discussion.**

3. Upcoming Check-writes (cut-off dates) – February 2, 8, 15, 22

4. Agenda items
   - **Date Change: YP851/852**
   - **Crisis Services Usage**
   - **AO Pop Groups**
   - NPI Beta Test Volunteers Needed
   - Reminder…Send in NPI data
   - IPRS Questions or Concerns
   - MMIS Updates – Tim Sullivan & Chris Ferrell
   - Medicaid Questions or Concerns

5. DMH and/or EDS concluding remarks.

   a. For **North Carolina Medicaid** claim questions / inquiries, please call EDS Provider Services at 1-800-688-6696 or 1-919-851-8888 and enter the appropriate extension listed below or 0 for the operator.

      i. Physician phone analyst (i.e. Independent mental Health Providers – 4706
      ii. Hospital phone analyst (i.e. Enhanced Service Providers / LMEs) - 4704

6. Roll Call Updates

Next Meeting: February 7, 2007

For assistance with IPRS claims, adjustments, R2Web, accessing application, etc.
Call the IPRS Help Desk – 1-800-688-6696, ext 53355 or 919-816-4355
, M-F, 8 a.m.-4:30 p.m., excluding holidays.

IPRS Question and Answer email address – iprs.qanda@ncmail.net

ADMINISTRATION NOTES (10:30 a.m. AREA PROGRAMS CONFERENCE CALL)	
Item No.	**Topics**
1.	Roll Call
2.	Please mute phones or refrain from excess activity to help with communications. Please state your name and which "area program" you are from when you speak. **Also, please do not place IPRS Core Team call on hold because of potential distraction to call discussion.**
3.	Upcoming Check-writes (cut-off dates) – February 2, **8**, 15, 22 – Reminder - check-write cutoff date will be Thursday beginning February 8 Q: Janet (Wilson-Green) - Since check-write cutoff is changing to Thursday, do the voids and adjustments need to be done a day ahead of time? A: Mike (EDS) – via the NCECS Web Tool or the 837? Janet - 837 – same cutoff for the voids and replacements A: Eric (DMH) Clarification – the Check-write cutoff will be Thursday; the actual check-write process will not start until Friday Q: Jeanna (Catawba) – So does this mean that the electronic transfers do not change; we just have to have everything in by Thursday at 5pm. We'll still get paid the same day? A: Eric (DMH) – That's correct.
4.	**Agenda items** There are no new agenda items. Items were inadvertently left on the agenda. However, as far as the items are concerned, there is no change in what was communicated last week. **Q:** Jeanna (Catawba) – I was not able to attend last week. Will you review the agenda items to make sure I am clear? **A:** Thelma (DMH) **Date Change: YP851/852 –** When implemented, put October 2, 2006 as the effective date; was asked by upper management to move the effective date back to July 1, 2006. Any claims for the public psychiatry funds can be submitted for dates of service back to July 1, 2006 and forward. Also, there was an issue with the account number and that has been corrected. This Friday adjustments will be done on those claims to have funds taken out of the correct account. This will be seamless to you, but you will see it on your 835. **Crisis Services Usage –** We had been asked to ask you if there were any issues using those accounts/pop groups because of no activity. It was reported that some of the LMEs were just now finalizing contracts and we should start seeing transactions against those pop groups soon. **Q:** Jeanna (Catawba) – Did you get an e-mail from Catawba regarding how those funds could be used? E-mail was sent twice – January 16 and January 22, 2007. Can someone clarify that? Some have the impression that money placed into this crisis pop was part of the original money for the expansion and that LMEs had to use money as part of the regional crisis plan and individual LMEs could not use it how they wanted to, but that it had to be used in conjunction with the region. **A:** Thelma (DMH) – don't remember receiving e-mail. Thelma will follow up. **AO Pop Groups –** noticed that AO pop groups were being used the way they used to. However, now AO pop groups should only be used when you have sent a client to a provider, thinking the client will be enrolled in an IPRS pop group or was eligible for

	Medicaid and they turned out not to be eligible for Medicaid or eligible for an IPRS pop group. This is a pop group that allows payment to that provider who in good faith did the assessment or did the service and the client is not eligible for IPRS or Medicaid. So, this is for new clients, not eligible for anything else and the provider is being paid for a one time service. Any clients that are eligible for an IPRS pop group should be placed in the IPRS pop group immediately instead of being placed in the AO pop group first. Please pass this information on to your clinical people. The AO pop groups is a mechanism to pay providers for clients that are not otherwise eligible for IPRS or Medicaid **Q:** Terry (Eastpointe) – in that pop group, you are paying for more than just an assessment because there are a certain number of units for community support, etc? **A:** Thelma (DMH) - Yes, there is a list of services under the AO pop group that can be billed for. But, can only be billed for 1 of those services per event and 2 events per fiscal year; very limited benefit. Again, only used to reimburse providers for clients that are not IPRS or Medicaid eligible. **Reminder…Send in NPI data** – Also send your NPI billing provider number to IPRS Q & A. Forward to Medicaid as well. Also send in zip code information Cheryl – DMH only needs NPI information for billing provider numbers. For your attending providers, look at PT screens to make sure information is correct for your direct enrolled providers. If it is an IPRS-only provider, can enter information. DMH is only entering information for billing providers. **Q:** Jeanna (Catawba) – Any word from DMA on dealing with enhanced alpha suffixes? **A:** Cheryl (DMH) – Request was sent over asking DMA to populate NPI information down to the alpha suffix level. This was sent over to Provider Services. **A:** Thelma (DMH) – Project leads passed this over to Provider Services. Please help by watching reports to see if the information is populated. If not, additional e-mails will be sent to the project leads. **A:** Cheryl (DMH) Also communicate with providers that they need to let Medicaid know to associate NPI number with the service level numbers in addition to the core number. **Q:** Sharlene (Albemarle) – I have NPI numbers for core numbers. Do I need to get individual NPI numbers for each service level number or will that one NPI number take care of it? **A:** Cheryl (DMH) – I have seen an instance where someone has gotten individual NPI number for each alpha suffix. It is up to you to decide. If you want to use one NPI number for each service level number, that is fine. If you want to get one for each service level numbers, that is fine as well. **A**: Again, it needs to be communicated to DMA. **Q:** Sharlene - So, when we send in the Medicaid collection form, would we also add the service level provider numbers? **A:** Cheryl (DMH) - Yes. Your form needs to contain every legacy number that you bill with – whether it is a billing provider number or attending provider number

	Kim (Neuse) – I look at IPVR0552, make copy of document and fax to providers and tell them they need to include this information for their service level numbers. **Q:** Agnes (Cumberland) – some providers don't have core numbers, but have NPI numbers. Is it absolutely necessary to have core numbers or Medicaid direct enrolled provider number and NPI number? **A:** Cheryl (DMH) – if they wish to be paid by Medicaid, yes. For IPRS, for endorsed services, yes. Starting in May, they will need both the legacy number and NPI number if they are a typical provider. Even after all NPI numbers are in, if you get new providers that become endorsed and enrolled, they will still need to go through endorsement process with the LME and when they go through the enrollment process with DMA, they will be required to send in the NPI # if they provide healthcare service. So, just because they get an NPI #, does not mean that endorsement and enrollment process will be eliminated. **Q:** Tom (Western Highlands) – I'm getting conflicting information about the use of NPI # on the 837 and want to ensure that I am HIPAA compliant. I hear the statement "You must use your NPI on the 837". But, there are situations where a provider is atypical and doesn't require an NPI. Yet, we are going to continue to submit claims for those providers on the 837. Which policy do I follow to ensure I am HIPAA-compliant? **A:** Cheryl (DMH) - Add on the end of the statement "if the provider has an NPI." If the provider does not have an NPI, it is still HIPAA compliant for you to report his claims using an 837. That's why the two values are allowed on those different provider segments for you to provide either NPI or a legacy number. If a provider has an NPI and you report the claim using a legacy number, you will be out of HIPAA compliance. But, if a provider is atypical and therefore does not have an NPI, it is perfectly acceptable for you to report his claims on an 837 transaction. **Q:** Tom (Western Highlands) – And Medicaid supports this? **A:** Cheryl (DMH) – Yes. We're following Medicaid's lead. **Q:** Tom (Western Highlands) – Is that specified in any supporting memo or publication? **A:** Cheryl (DMH) - I don't know all of Medicaid's publications, but there is a website specifically for NPI information. If it's anywhere, it would be on that website. **A:** Thelma (DMH) - On the white paper sent out for NPI, it does get a little confusing, because it talks about atypical providers briefly and then talks about typical because it assumes that most providers are typical. So, just keep that in mind when reading. The "atypical" part is in a separate section in the back. Again, you will be HIPAA compliant if you submit your atypical providers with the legacy numbers. And yes, DMA is definitely following this. Again, we can not tell a provider if they are a health care provider or not. They have to decide. In that white paper, it gives examples of what is considered health care services. **Q:** Tom (Western Highlands) – The distinction is that an 837 is a health care service claim submission. So when a provider is atypical – definition supports that the provider is NOT providing a health care service. **A:** Thelma (DMH) - Will bring up to DMA, but is positive that they are following this. **Q:** Jeanna (Catawba) – Regarding the training on "usage of paper claims", DMH was

	saying that by a particular date, you have to use the NPI# for the referring provider. They were not giving an option in a transition. **A:** Cheryl (DMH) There's not going to be a transition. Starting with the May 18th check-write, you have to use your NPI if you have one. **Q:** Jeanna (Catawba) So, if you don't have one, do you use your current legacy number as your NPI? **A:** Cheryl (DMH) - No, the 837 map has changed to use either a legacy number OR an NPI. That's why we had your vendors on the phone because they have to make coding changes. If the attending provider is typical, then the NPI number would be sent. If the attending provider is atypical, the legacy number would be sent. **Q:** Tom (Western Highlands) – I think the difference lies in that DMA – if it's a Medicaid-reimbursable service, it is typical. **A:** Cheryl (DMH) – that's not true. Medicaid has atypical services. For instance, some of the CAP, they have declared as atypical. Their providers will be able to send in claims using their legacy numbers. **Q:** Tom - We're going to have problems determining if a provider is atypical or typical and needs an NPI or not. **A:** Cheryl (DMH) - That's not for you to decide. It is for the provider to decide. You go based on the decision they make and send in the claim. **Q:** Tom - But, I do run the risk of accepting the claim, in EDS' opinion, that should be reported with an NPI. **A:** Cheryl - If that provider has a type/spec that DMA has decided is typical, you will get a denial that says that you can't report that type of claim using a legacy number. That will be your mechanism to go back to the provider stating that DMA has decided this is a typical service and if you want to get paid by Medicaid, you will have to get an NPI number. **Q:** Tom - But, DMA has not said that these services are not typical. You're telling me it's up to the provider to decide. **A:** Cheryl - Medicaid is going to go through a process for the providers who they feel should be providing health care services – as an example, physicians would need an NPI. They will go by type/specialty and identify those providers who should have an NPI and who have not yet reported their NPI to Medicaid. These providers will be getting a letter from Medicaid, letting them know that Medicaid is expecting them to have an NPI. If they can justify why they should not get an NPI, Medicaid will respond to that. That should be helpful to the providers. **Q:** Tom – What about on the IPRS side - group living, supported living - where one provider may think those are typical services, while another provider thinks they are atypical services? Where is the common ground there? Am I at risk paying those claims out, but having them deny upstream? **A:** Cheryl – The Division will not specify which service will be defined as typical or atypical. It is up to the providers to decide whether or not they provide health care service and based on that, whether or not they are getting an NPI.

	Q: Kelly (Durham) – If two (2) providers are providing the same service and one feels they are typical and the other is atypical and IPRS is going to require an NPI for both providers, how are we getting past this? How do we make that provider understand they are typical when they don't think they are? **A:** We are not requiring NPI by service on the IPRS side. The only thing we are doing is when a claim comes in with a legacy number we are going to make sure that the provider is identified as atypical. If that provider is identified as atypical, then that claim will go through. We are not going to say, oh, this is group home and we've decided that everyone that is group home is typical and then deny that claim. We don't have anything like that in the system because it is not a service by service decision. It could be that one provider who is doing group home for IPRS does a completely different service and for that other service, they may have to get an NPI. When they get that NPI, you now have to report their group home services using that NPI. So, even if we were to decide, which we have not decided, but even if we were to say that we at the state think that group home is not a health care service and therefore we feel that no one needs an NPI when these services are reported, it is possible that a group home provider does something else (health care service related) and has an NPI, you have to report their services using their NPI. So, it's not a service by service determination as far as the system is concerned. It is for the provider to look at all of the services they provide and determine if any of the services they provide is a health care service. If one of them is a health care service, then that provider must get an NPI and you must report all claims for that provider using their NPI. So, we don't have anything set up in the system that says that we consider a service typical or atypical because it is not at the service level, it's at the provider level. So, if the provider reports to you and says "I'm not getting an NPI, I have decided I am atypical," this is all that can be relied upon. Now if somebody comes back to that provider and says, "You should have been typical and you should have acquired an NPI," the fault is not going to be with you because you have relied upon what the provider told you and it is the provider's decision. It's not an LME decision. If you find out the provider is typical and has an NPI and you report their claims using their legacy number, then that's a different issue. But, if the provider made the decision to be atypical and you report claims using their legacy number, then that's fine. You're still HIPAA compliant. **Q:** Jeanna (Catawba) – If I had a provider who is considered typical and has an NPI, they bill enhanced services, and they also bill state-only services. As long as I have the NPI set up in the numbers I'm submitting to you, a legacy number, regardless of what that legacy number is and you can go back and match that legacy number to the provider and that NPI, then I'm good. Correct? **A:** Cheryl – NO. If that provider is typical, your claims have to contain their NPI, regardless of the service that is being reported on that claim. If they have an NPI, you must report ALL of their services using their NPI, whether state-only services or not. Don't worry about the details of the service being reported. Just know that the claims of any provider that is typical must contain an NPI.

IPRS Questions or Concerns

Q: Jeanna (Catawba) – In last week's minutes, there was a question about how we bill psychiatric support funds. Originally we were told to send in provider-specific rates: the physician's individual enrolled number would have provider-specific rates. So, do I understand we don't need to do that any longer? We are going to bill using our 3404912 # and therefore would automatically have the correct rates assigned?

A: Cheryl (DMH) – No. As the billing provider, send in the claims with your 34049# not with your physician group number. In last week's notes, the attending provider was a direct enrolled physician number, so like a Medicaid physician number, and the billing provider they were using was their physician group number, not their 34049# and the claim for the billing provider needs to have the 34049#. The attending number needs to be the number of the actual person providing the service. Whatever number you are using as the attending provider is the number under which you need to establish the rate.

Q: Jeanna - So that would be the physician's direct enrolled number for Medicaid as the attending provider?

A: Cheryl - Yes. In the example I gave you. Some people are still reporting using IPRS-only numbers, but most people are now using the Medicaid direct enrolled numbers.

A: Thelma (DMH) - Send those rates in to Rick Debell.

Q: Sharlene (Albemarle) – We bill some of these codes under 34049# with our doctor's direct enrolled number, but we got back 79 denials saying type/specialty is not correct. Should I send those examples to IPRS Q and A?

A: Cheryl – Yes. I'm guessing it didn't come in with your 34049#, but we'll take a look at it.

Q: Sharlene – It was on my IPRS RA denials with my 34049# at the top and doctor's direct enrolled attending number beside it.

A: Cheryl - You can't go by the RA you get. On the IPRS side, all of the claims are sent back (on the RA) under your base number. That does not actually reflect the billing provider number. On your 835, it would be under the TS3 for that particular attending provider or it may be easier for you to look in your system.

Q: Angela (Sandhills) – Any luck finding documentation regarding the 8-minute rule?

A: Thelma (DMH) - No, we sent out some e-mails to upper management and have not gotten any responses yet. We'll bring this up in Divisional Workgroup Meeting.

Medicaid Questions or Concerns

Q: Kelly (Durham) – I'm trying to process community support claims for May dates of service (May 1, 2 and 3). The provider didn't become enrolled until June 1 so they can't bill directly to Medicaid. We had to bill those claims; however, I keep getting denials saying my type/specialty can't bill those claims to Medicaid.

A: Thelma (DMH) – Send those in to IPRS Qand A and we'll forward them to Medicaid
Q: Agnes (Cumberland) – I have a contract provider who is a licensed clinical addiction specialist. I'm looking at the fee schedule and from what I can see they can only bill using H codes. But, I'm being told they can also use CPT codes. I need clarification.

	A: Cheryl (DMH) – If they are on the IPVR0551 and the type/specialty is 109/129, then they can only report with the H codes. This is according to the Medicaid January 2005 Special Bulletin. For "certified" clinical supervisor or a "certified" clinical addiction specialist – either one of those two, they can only report using the H codes. There are lots of type/specialties listed in this bulletin. **Q:** Agnes - So, if they don't have this type/specialty, that means they can report using CPT codes? **A:** Cheryl - It depends on their type/specialty. You may want to refer to this Special Bulletin. It has 9 different specialties listed and it tells you the codes each specialty can bill. The report is IPVR0551. **Q:** Lynn (Rockingham) – I had sent an e-mail a few weeks ago addressing this because we have some addiction specialist here that said something changed as far as a law last summer and they had talked with Spencer, but he never got back with them. I sent an e-mail trying to get clarification because they said that because of that, they would now be able to bill CPT codes. **A:** Thelma - We forwarded that e-mail to Spencer and he didn't remember that conversation. I don't think that has gone any further. I'll bring it up to him again for an update on the status. **Q:** Terry (Eastpointe) – I have done some research this week, but still have no answer for denial code 286 that's requiring the CDSA number. I have an e-mail that was sent to Shannon Johnson and her response at the time was "claims with recipients ages 0-3 require CDSA referral number in block 19 whenever case management code is billed by a non-CDSA provider and also area mental health providers cannot bill T1017-HI for recipients 0-3 or if recipient has had MRDD on their eligibility file. I've called the CDSA this week and they have no idea what I'm talking about. They say they don't make referral for case management. They only refer out for outpatient therapy. Then I had a provider who called the CDSA and they told her they didn't know what she was talking about and maybe she needed the physician's number who authorized the services, which was done at a clinic. From my understanding, this was referred to Carol Robertson. We have a lot of denials and need clarification. **A:** Debbie (EDS) – For the 286 denial that is the PCP, the referral number that is on the card goes in Block 19. **Q:** Terry – For whose card? **A:** Debbie – Referral number from the Carolina Access – where they have PCP – the referral number from the recipient's card goes in Block 19. **Q:** Isn't this an issue EDS is trying to fix? **Q:** Danita (Pathways) – Our problem with this is its only children ages 3-4 and it's a problem with the edits the state is working on. **Q:** Kelly (Durham) That was my understanding also. We need clarification of the memo. **A:** Thelma (DMH) – When we brought this up to Carol and she said that the CDSA should know what the referral number is and should be able to give that to you. If you would write this up, I will forward it over to Tara Larson, who was Carol Robertson's boss and see what she says.

Q: Terry - So, if it is ages 0-3, these should be able to be authorized and sent back out and that there shouldn't be a problem?

A: Thelma - No, I'm not saying that. I'm saying that CDSA referral number is required for children 1-3 in order to be paid out of Medicaid side. Carol Robertson had said that the CDSA centers should know the referral numbers to give to you so you can put it on the claims. So, if that is not happening, we need to let Tara Larson know, who can possibly do something about it.

A: Cheryl – If you could put in there specifically which CDSAs you're having problems with, someone from DMA may be able to contact them and give them the information they need. The ones for ages 3-4 – EDS is still working on that memo with Medicaid.

Q: Danita (Pathways) -- Any update on Residential Billing?

A: Thelma (DMH) - No. We have a meeting this afternoon with DMA and that is one of the topics we will be discussing. I hope to have some information next week. What I've heard is that if your residential providers were one of the few that were endorsed and then enrolled by DMA, they need to bill Medicaid directly. The issue is around those providers that are endorsed, but not yet enrolled with Medicaid. The latest is that you are to continue to bill for them. If they are not endorsed and not enrolled, you are not to bill for them any longer. We'll see if we get any more information this afternoon.

Q: Tom (Western Highlands) – Do the edits accommodate that?

A: Thelma – We held off on the edits at this point. So, continue to bill the way you were billing before 12/31/06. After we get clarification from DMA and our Division leaders on what is happening, we'll see what we need to do. But, for now, for this coming weekend, if you have claims you need to submit for endorsed, but not enrolled residential providers, submit them in the same manner as before 12/31/06.

Q: Danita (Pathways) – If we could also address the problem with Value Options because a lot of our providers have not gotten that authorization because they thought they had to have their number. So, they don't know what to do for that specific part of it.

A: Thelma (DMH) – So, your providers don't know what to do about getting Value Options approval. Tell me again.

A: Danita – We quit billing 12/31, so our providers have been trying to get Value Options authorization because they don't have a provider number. At this point, they'll need to get Value Options authorization under Pathways number. Is Value Options going to do that?

A: Thelma – I'll ask.

Q: Karen (Alamance-Caswell) – 90808 procedure code – getting denials for them. They're not listed on the Procedure Code Pricing Inquiry, but still in the CPT Handbook. Which one is right? Which code should we be using?

A: Cheryl – 90808 is no longer covered by IPRS. It is a valid CPT code (75+ minutes); however, it's not an IPRS-covered service. The Division decided they would no longer cover that code so it was removed from the Array of Services. So, for IPRS-only clients, you will get denials. You can bill using 90806 (45-50 minutes). You will not get reimbursed for the additional minutes.

DMH and/or EDS Concluding Remarks:

	For North Carolina Medicaid claim questions / inquires please call EDS Provider Services at 1-800-688-6696 or 1-919-851-8888 and enter the appropriate extension listed below or 0 for the operator. o Physician phone analyst (i.e. Independent Mental Health Providers)-4706 o Hospital phone analyst (i.e. Enhanced Service Providers / LMEs) - 4707 **Roll Call Updates**